Department of Public Health and Human Services	Section: ELIGIBILITY & BENEFIT DETERMINATION
FOOD STAMP PROGRAM	Subject: Deductions (Medical)

Supersedes: FS 602-3 (10/01/04)

References: 7 CFR 273.9(d)(1) through (6), 7 CFR 273.10(d)

GENERAL RULE -- Household members who are elderly or disabled are eligible for a medical deduction for their total medical expenses minus any amount payable by a third party, such as health insurance, exceeding $35 per month per household.

NOTE: An elderly or disabled household member who is an ineligible alien or SSN disqualified coded 'DS' or is disqualified coded 'DQ' or 'DF' is not eligible to receive the medical expense deduction.

The OPA Case Manager enters the entire non-reimbursable amount of the medical expense. TEAMS totals medical expenses coded against all elderly or disabled household members and deducts the $35 before determining the amount of the deduction for the household.

HOUSEHOLDS ELIGIBLE FOR THE DEDUCTION

Elderly - households with an elderly (age 60 or older) member.

Disabled - households with a disabled member (FS 0-4).

Deceased - households with a legal obligation to pay medical expenses for deceased individuals who met the definition of elderly or disabled prior to dying and were members of the household *at the time of death or time they entered a medical facility prior to death in the facility.*

Recent Absence - households with a legal obligation to pay medical expenses for an elderly or a disabled individual who was a household member immediately prior to entering a hospital or nursing home.

Example: An elderly husband and wife were not receiving food stamp benefits. The husband was admitted to the hospital in September. The wife applies for food stamps in October. The husband's medical expenses are allowed because he is required to be a part of his wife's household.

INDIVIDUALS NOT ELIGIBLE FOR DEDUCTION

A spouse or other persons receiving benefits as a dependent of the SSI or SSDI recipient are not eligible for the medical expense deduction.

APPLICATION/ RECERTIFICATION

Households are required to report and verify the amount of medical expenses (including the amount of reimbursements) at application and recertification.

At recertification the household must verify previously unreported medical expenses and total recurring medical expenses that have changed by more than $25. Verification of total medical expenses claimed by the household that are unchanged or have changed by $25 or less is not required unless the information is incomplete, inaccurate, inconsistent, or outdated.

Actual expenses or other documentary verification must be provided before an expense is allowed. Verification of other factors such as allowable services provided or the eligibility of the person incurring the cost is only required if questionable.

The OPA Case Manager should reasonably attempt to verify information with a collateral contact when documentary evidence cannot be obtained or is insufficient to make a determination for the amount of the deduction. The OPA Case Manager must wait until an expense or verification of third party payment is provided if the obligated amount is still questionable.

The OPA Case Manager must document in case notes the medical expenses allowed for the deduction.

Example: A household has a recertification in May. The total recurring expenses have not changed, but the household reports a new expense of $10 a month for prescriptions. The OPA Case Manager requests verification of this new expense but cannot request verification of the recurring expenses that have not changed unless information about those expenses appear to be incomplete, inaccurate, inconsistent or outdated.

CHANGES IN MEDICAL EXPENSES

A household may report changes in medical expenses during its certification period. The OPA Case Manager is required to take an action on the change according to the household's reporting requirements within 10 calendar days (FS 1501-3 and 1501-4).

The household must be allowed 10 calendar days from the date of the TEAMS notice to provide verification of the reported change. The notice must also inform the household if verification is not provided within 10 days of the request, the medical expense will not be allowed.

The OPA Case Manager must act on changes in medical expenses reported by a source other than the household if the changes are

considered verified upon receipt and do not require verification from the household.

Change Reporting - cash option not paid for six months.

1. If Medicaid closes anytime during the certification /recertification period because the household did not pay cash option for six months, the cash option expense is allowed until recertification if:

   a. the household's medical expenses are questionable; **and,**

   b. to determine its current anticipated medical expenses at the time Medicaid closes requires contact with the household.

   The cash option expense is removed if the household's anticipated medical expenses at the time Medicaid closes can be determined without contacting the household.

   NOTE: In most cases the household's current anticipated medical expenses will be questionable and would require contact with the household, so the cash option expense is allowed until recertification but this needs to be evaluated on a case-by-case basis.

   Example: It is determined at certification the household's Medicaid spend down is $250. Verified medical expenses are: $125 health insurance premium; and, the average monthly recurring expenses are $150. The household anticipates paying $125 cash option. The medical deduction is $125 health insurance premium and $125 cash option.

   In month three of the certification period the household stops paying cash option. Medicaid closes the end of month eight of the certification period because the cash option was not paid for the last six months.

   The $125 cash option expense continues to be allowed while it is being incurred. When Medicaid closes, the cash option expense continues to be allowed in month nine through the certification period because the household's current medical expenses are questionable and would require contact with the household.

Six Month Reporting - cash option not paid for six months.

1. If Medicaid closes in the middle of the six month report period because the household did not pay cash option for six months, the cash option expense is allowed until recertification if:

   a. the household's medical expenses are questionable; **and,**

   b. to determine its current anticipated medical expenses at the time Medicaid closes requires contact with the household.

The cash option expense is removed if the household's anticipated medical expenses at the time Medicaid closes can be determined without contacting the household.

NOTE: In most cases the household's current anticipated medical expenses will be questionable and will require contact with the household, so the cash option expense is allowed until recertification but this needs to be evaluated on a case by case basis.

Example: It is determined at certification the household's Medicaid spend down is $250. Verified medical expenses are: $125 health insurance premium; and, the average monthly recurring expenses are $150. The household anticipates paying $125 cash option. The medical deduction is $125 health insurance premium and $125 cash option.

In month three of the six month report period the household stops paying cash option. Medicaid closes the end of month eight of the certification period because the cash option was not paid for the last six months.

The $125 cash option expense is allowed at the six month report period for month seven because the cash option payment is still being incurred; it does not matter if actually paid.

The cash option is allowed for month nine through the remainder of the certification period because the household's anticipated medical expenses are questionable and would require contact with the household.

2. If Medicaid closes in month six of the six month report period because the household did not pay cash option for six months, the

household's anticipated medical expenses must be verified since it is a known change at the six month report period.

Medical expenses submitted to meet an incurment are treated as a reported change. The OPA Case Manager must evaluate the medical expense each time new bills or co-payments are provided that were not previously averaged.

Example: A household submits a co-pay for a prescription. The OPA Case Manager must determine if the co-pay for the prescription is a co-pay for a recurring prescription that has already been averaged or if it is a co-pay for a new prescription.

If it is a new prescription, the OPA Case Manager must send the household a notice for information asking if the new prescription is anticipated to be an ongoing monthly expense or if it is a one-time expense.

If the household does not respond or if the household responds indicating it is anticipated to be a one-time prescription, the amount of the co-pay is allowed as a one-time expense.

If the household responds the new prescription is anticipated to be a monthly expense, the co-pay amount is added to the average monthly medical expense.

The OPA Case Manager must document in case notes specific information about the change in the medical expense reported such as name of prescription, amount of prescription or co-pay, date the change was reported, date prescription was filled even if the change reported does not change the benefit amount.

ALLOWABLE MEDICAL EXPENSE

A medical expense can only be allowed once as a medical deduction.

Example: The household has an installment agreement with a provider for a $1,200 medical expense. The agreement is the household pays the provider $100 for 12 months. The $100 monthly expense is allowed as a deduction for 12 months whether or not the balance is still due after 12 months.

Medical expenses are allowed when they become due. Past due expenses are not allowed. Medical expenses carried forward from past billing periods are not allowed even if they are included with the most

recent billing and actually paid by the household. Once an expense becomes past due, it remains past due.

The OPA Case Manager can use the expense for the next regular issuance as long as the household reported the change within 30 days of being billed. If the expense was not reported within 30 days of billing, it is not allowed unless it meets one of the exceptions (e.g., installments, averaged over period of intended use, averaged over period until next recertification).

NOTE: An expense is considered 'past due' 30 days after the billing date. 'Past due' means the payment is overdue to the provider not overdue at the time of application or recertification. Medical expenses pending verification of third party reimbursement are not considered 'past due' until 30 days after the household's receipt of verification of their obligated portion after third party payment.

The following expenses are not considered 'past due':

1. One-time medical expenses averaged over the period until the next recertification (e.g., bill for gall bladder surgery);

2. Expenses paid on an installment plan; and,

3. Expenses averaged over the period of intended use (e.g., bill for quarterly health insurance).

Intent to pay is not considered when allowing a medical expense. If a household states it will not be paying a medical expense, it is used as a medical deduction. If the household states an intention for someone else to pay the medical expense, the expense is being reimbursed and is not allowed as a deduction.

Third party payments, such as health insurance payment to providers, are also known as reimbursements. Any medical expense covered by a third party cannot be allowed as a deduction. The non-reimbursable portion of the expense is allowed as a deduction at the time the amount of the reimbursement is received or can be verified. A deduction cannot be allowed until it is verified (e.g., a health insurance policy and a collateral contact confirm the exact obligated amount is the $100 deductible) regardless of the time it takes for the reimbursement.

If a household has a deductible before the insurance pays any expenses, the household is allowed the deductible as an expense regardless of whether or not it has been paid or met. In addition, if it is verified the

insurance company only pays a certain percentage of further expenses, the OPA Case Manager anticipates expenses and allows the percentage the household is responsible for paying.

A household choosing the 'Medically Needy Cash Option' to meet its incurment is considered to have incurred and paid that amount of medical expenses. Fiscal authorization is not required prior to allowing the deduction.

NOTE: The amount of the cash option expense anticipated to be incurred after all recurring monthly medical expenses are averaged continues as long as the household anticipates paying the expense.

BUDGETING THE EXPENSE

Households reporting **one-time** only medical expenses may choose to:

1. Have a one-time expense; or,

2. Average the expense over the remaining months until recertification.

Recurring monthly medical expenses are **averaged** when the household anticipates the expenses to continue monthly. Prescriptions and Medicaid co-payments are examples of recurring medical expenses. Each prescription and co-pay must be evaluated to determine if it recurs monthly to be allowed as a monthly recurring medical expense.

Non-monthly recurring expenses can be averaged over the period of intended use or allowed when the bill becomes due.

1. A prescription for a three-month supply of medication can be averaged over three months or used once every three months.

2. An annual health insurance premium can be averaged over 12 months or allowed once annually.

   NOTE: It is not an option to average expenses for the number of months until the next recertification.

If the household has an **installment payment agreement** with a provider, the specific agreed upon monthly payment is allowed even if a payment is not being made during the period of the agreement. Once the period of agreement is past, any unpaid amount is a past due expense and is not allowable. If the installment agreement is renegotiated with a collection agency, only the terms negotiated with the provider are allowed.

The payment agreement does not have to be a formal contract. A mutually recognized verbal or written agreement with the provider and the household is sufficient (e.g., $25 monthly payments until paid in full).

TEAMS CODING

All medical expense codes are processed the same way by TEAMS. **The OPA Case Manager must enter a 'D' code in the 'Disabled Indicator' field on the FS SEPA screen for each disabled household member coded 'IN' on FS SEPA to receive the medical deduction.** TEAMS reads the date of birth on SSDO and allows the medical deduction coded against an elderly member. The medical deduction for an elderly individual begins the month after the individual's 60th birthday.

ME Medical Expense

MC Medicare Premium (TEAMS requires a Medicare # on the EPME screen before this code is valid)

MD Medical Expense Deceased

BD Blindness Expense Deduction

HI Health Insurance

TEAMS WORK AROUND FOR A DECEASED MEMBER

When there are not any elderly or disabled household members, the current work around is:

1. Enter a 'D' on FS SEPA for a household member coded 'IN';
2. Enter 'MD' and the expenses on EXPE against the person the 'D' was entered;
3. Since the 'D' also allows an excess shelter deduction, review EXAD to confirm the only change was the medical expense deduction and the right allotment amount is being issued;
4. Document in case notes with sufficient details of how the case was processed.

Allowable Medical Expenses

Medical Bill	Allowable for FS Expense
Past due obligations	No
Special diets	No, items that can be purchased with food stamps cannot be allowed as a medical expense. There is no exception for tube feeding.
Dental and medical care including psychotherapy and rehabilitation services.	Yes, if provided by a licensed practitioner authorized by State Law or other qualified health professional.
Costs reimbursable or paid by a third party.	No, Medicaid paid travel and premiums paid by THPL are reimbursements.
Prescriptions, over-the-counter drugs, medical supplies, sick room equipment (including rental) or other equipment.	Yes, each must be prescribed by a licensed practitioner.
Postage for mail-prescription drugs.	Yes
Medicare premiums	Yes, unless paid by a third party (QMB or SLMB). The month after QMB approval the Medicare premium expense cannot be given. The month of SLMB approval the expense is not allowed.
Health, hospitalization, and ambulance insurance policy premiums.	Yes, only the portion of the premium assigned to the elderly or disabled household member. If the policy does not state the amount of the premium for each insured individual, the premium is prorated among the insured household members. Only the prorated amount for the eligible member is considered a deduction.
Dentures, hearing aids and prosthetics.	Yes
Costs of attendant, homemaker, home health aide, child care or housekeeper services necessary because of age, infirmity or illness.	Yes, if the service is provided by someone outside the food stamp household. If the household provides the majority of the attendant's meals, deduct an amount equal to the one-person coupon allotment. If the attendant care costs qualify under the medical and dependent care deduction, allow as a medical deduction.
Current cash option payments made to meet an incurment obligation of Medicaid recipients.	Yes, if the household anticipates paying the cash option.

Medical Bill	Allowable for FS Expense
Medicaid co-payments	Yes, generally the best estimate for co-payments is to anticipate for initial months and average for ongoing eligibility.
Cancer or other specialized insurance policy costs.	Yes, if the policy itself states the monies are intended to be used to cover medical expenses. If the policy pays personal debt (car loan, mortgage etc.), the premium is not an allowable expense.
Prescription for home meal delivery service.	No, generally payable with food stamps.
Loan payments for medical debt.	Yes, including medical expenses charged to a credit card. The interest or late fees are not allowed as part of the deduction.
Prescription to buy exercise equipment or get exercise at a health club.	No, club membership or purchase of equipment is not allowed. The services of a medical provider such as a physical therapist would be allowed.
Acupuncture	Yes
Chiropractor	Yes
Reasonable costs of transportation and lodging to obtain medical treatment or services; including, the cost of a trip to a pharmacy or other location to fill a prescription for medicine, dentures, a hearing aid, eye glasses, etc.	Yes, all costs must be verified and not exceed current lodging reimbursement rates for state employees and Medicaid travel costs for transportation. Meals are not an allowable expense. Reminder: expenses being reimbursed are not allowed as a deduction. If Medicaid travel will reimburse the expense, it cannot be allowed for FS.
Prescription eye glasses or contacts	Yes, if prescribed by an ophthalmologist or by an optometrist.
Securing and maintaining 'service animals' such as seeing eye dogs, hearing guide dogs and monkeys specially trained to provide a service to the disabled.	Yes, in addition to the initial purchase of the animal, animal food and veterinary bills are also allowed as a deduction.
Medic Alert System, Life Line or other home monitoring system.	Yes, as follows: The basic fee for the telephone is a utility expense; and, The additional expense for the medic alert system is an allowable medical expense.
Hospitalization or outpatient treatment, nursing care and nursing home care.	Yes, including payments by the household for an individual who was a household member immediately prior to entering a hospital or nursing home. Only medical costs are allowed. The cost of room and board is not allowed.